Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Medi Smart Systems P.O. Box 330279 Houston, TX 77233-0279	MFDR Tracking #: M4-06-3922-01 DWC Cl Injured Em Date o
Respondent Name and Box #: American Home Assurance Co. Rep. Box #: 19	Employer Insurance Carr

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary as stated on the Table of Disputed Services: "All codes are valid and all codes have been paid on in the pass by the carrier. Examples were sent in to show proof [99002, E0236, E0249]. This code is also valid & has always been sued [L0515]."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $1,952.00
3. CMS 1500s
4. EOBs

Sent
AUG 0 8 2008
TX DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: A position summary was not submitted with the initial response. A supplement response was sent which states, in part, "Carrier has previously responded to this dispute on 03/01/2006. Carrier maintains its position as outlined in the original response."

Principle Documentation:

1. Response to DWC 60

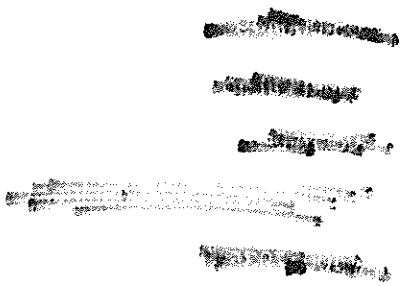
PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Reasons	Part V Reference	Amount Ordered
08/12/05	CPT Code 99002	1, 1(18)	1, 2	$ 0.00
08/12/05 – 08/25/05	HCPCS Code E0236-RR ($44.25 x 125% = $55.32 x 14)	1, 2 (150)	1, 3	$774.48
08/12/05	HCPCS Code E0249-NU ($99.60 x 125%)	1, 2 (150)	1, 4	$124.50
08/12/05	HCPCS Code L0515	2, 2(150)	1, 5	$ 0.00
Total:				$898.98

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective for professional medical services on or after August 1, 2003, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "1 – This charge denied because an invalid code was submitted on the bill or if pharmacy bill charge denied because RX number was not submitted on the bill"; "2 – This procedure code or National Drug Code (NDC is not valid for this date of service. Resubmit the bill with a valid procedure code or National Drug Code (NDC)"; "1 (18) – Duplicate claim/service"; (2 (150) – Payment adjusted because the payer deems the information submitted does not support his level of service." The Division clarifies reason code 150 shall be used for medical necessity or fee denials. The Division



determines this is a fee dispute, as medical necessity has been established through preauthorization.

2. CPT Code 99002 for date of service 08/12/05 denied as ""1 – This charge denied because an invalid code was submitted on the bill or if pharmacy bill charge denied because RX number was not submitted on the bill" and1 (18) – Duplicate claim/service." According to 28 Texas Administrative Code Section 134.202(b) this is a valid code; however, it is considered to be a bundled code and not separately payable. Therefore, reimbursement is not recommended.
3. HCPCS Code E0236-RR for dates of service 08/12/05 through 08/25/05 (14 dates of service) was initially denied as "1 – This charge denied because an invalid code was submitted on the bill..." and "2 (150) – Payment adjusted because the payer deems the information submitted does not support this level of service." According to 28 TAC Section 134.202(b) this HCPCS code is a valid code. The Requestor submitted a prescription stating the "Cold therapy for post-op, for alleviation of pain and swelling" and the preauthorization approval for 14 days rental of the cold therapy unit. Therefore, per 28 TAC Section 134.202(c)(2)(A) reimbursement is recommended.
4. HCPCS Code E0249-NU for dates of service 08/12/05 was initially denied as "1 – This charge denied because an invalid code was submitted on the bill..." and "2 (150) – Payment adjusted because the payer deems the information submitted does not support this level of service." According to 28 TAC Section 134.202(b) this HCPCS code is a valid code. The Requestor submitted a prescription stating the "Cold therapy for post-op, for alleviation of pain and swelling" and the preauthorization approval for 14 days rental of the cold therapy unit. Therefore, per 28 TAC Section 134.202(c)(2)(A) reimbursement is recommended.
5. HCPCS Code L0515 for date of service 09/14/05. Per 28 TAC Section 134.202(c)(2) this HCPCS code was deleted on January 1, 2005; therefore, reimbursement cannot be recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

- Texas Labor Code Section. 413.011(a-d);
- Texas Labor Code Section. 413.031;
- Texas Labor Code Section. 413.0311;
- 28 Texas Administrative Code Section. 133.304;
- 28 Texas Administrative Code Section. 134.1;
- 28 Texas Administrative Code Section. 134.202; and
- Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $898.98 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature

Auditor III

Medical Fee Dispute Resolution

August 5, 2008
Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.